DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

NOV 14 2006

Mr. M. D. Goetz, Jr.
Commissioner of Finance and Administration
Tennessee Department of Finance and Administration
State Capitol, 1st Floor
Nashville, TN 37243

Dear Mr. Goetz:

We are pleased to inform you that the Tennessee Medicaid section 1115 demonstration amendment (TennCare) (No. 11-W-00151/4), has been approved through June 30, 2007, upon which date, unless reauthorized, all waivers and authorities granted to operate this demonstration will expire. Approval of the project modifications is granted under the authority of section 1115 of the Social Security Act (the Act).

Our approval of these amendments is subject to the limitations specified in the list of approved waivers and expenditure authorities. The State may deviate from Medicaid State plan requirements to the extent those requirements have been specifically waived or listed as inapplicable to demonstration expansion populations, or to the extent that the State has been granted expenditure authority for costs not otherwise matchable. The approval is also conditioned upon compliance with the enclosed Special Terms and Conditions (STCs), and is subject to our receiving your acknowledgement of the award and the acceptance of the STCs, Waiver List, and Expenditure Authorities within 30 days of the date of this letter. The Waiver List, Expenditure Authorities and STC numbers 1, 2, 12, 13, and 32, as well as Attachments B and H have been updated to reflect authorities granted within this approval.

Except as otherwise noted, any other change that you requested that is not reflected in this letter or the accompanying STCs is still under review and should not be considered approved. The waiver and expenditure authority lists and STCs enclosed have been updated only to reflect the three approved items as follows.

The Centers for Medicare & Medicaid Services (CMS) is approving the State's request to amend the demonstration in order to make the following changes:

- Establish a new TennCare Standard Spend Down (SSD) demonstration expansion population with an enrollment cap of 105,000 on the SSD program, with targeted enrollment of 100,000;
- Implement a "soft" pharmacy limit; and
- Adjust the per member per month (PMPM) expenditure authority of the "Duals" Member Eligibility Group.

The CMS is not approving the State's May 30, 2006, request to amend the demonstration in order to make the following change:

- An increase to the Meharry Medical College (MMC) supplemental pool payments from the maximum amount of $10 million to a maximum amount of $13 million beginning in State fiscal year 2006 cannot be granted as these additional MMC pool payments are inconsistent with CMS policy. The proposed actual cash pool payments increase to the MMC providers would cover part of the physician clinics' uncompensated care; therefore, they do not cover what would have been covered in other States through a disproportionate share program.

In your letter dated June 15, 2006, you also requested a 3-year renewal of the amended TennCare demonstration project under the authority of section 1115(e) of the Social Security Act, 42 U.S.C. section 1315(e). Since by this letter we are approving changes to the demonstration and have approved major changes to the demonstration over the past year, we do not believe it is appropriate to extend the project under the authority of section 1115(e). Moreover, we need to resolve Medicaid budget neutrality reporting and potential source of State funding issues before determining whether and if so under what conditions it would be appropriate to extend the demonstration project beyond its current June 30, 2007, expiration. Accordingly, we are not approving your request for a demonstration extension under the authority of section 1115(a). We look forward to working with Tennessee on the renewal of the TennCare demonstration under that authority.

If you have any questions concerning this demonstration project please contact Ms. Lane Terwilliger. Ms. Terwilliger's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations
7500 Security Boulevard
Mail stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: 410-786-2059
Facsimile: 410-786-5882
E-mail: lane.terwilliger@cms.hhs.gov

Official communications regarding program matters should be submitted simultaneously to the project officer and to Mr. Renard Murray, Associate Regional Administrator in our Atlanta Regional Office. Mr. Murray's address is:

Centers for Medicare & Medicaid Services
Atlanta Federal Center, 4th Floor
61 Forsyth Street, 4T20
Atlanta, GA 30303-8909

If you have concerns regarding CMS' oversight of this demonstration or additional questions, please contact Ms. Jean Sheil, Director, Family and Children's Health Programs Group, Center for Medicaid and State Operations, at (410) 786-5647.

Sincerely,

Leslie V. Norwalk, Esq.
Acting Administrator

Enclosures

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST

NUMBERS: **No. 11-W-00151/4**

TITLE: **TennCare Medicaid Section 1115 Demonstration**

AWARDEE: **Tennessee Department of Finance and Administration**

Title XIX Waivers

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in this list, shall apply to the demonstration project beginning July 1, 2002, through June 30, 2007. In addition, these waivers may only be implemented consistently with the approved Special Terms and Conditions (STCs).

1. **Amount, Duration, and Scope** **Section 1902(a)(10)(B)**

   To enable the State to modify the Medicaid benefit package to offer different pharmacy and non-pharmacy medical coverage and benefits to different segments of the Medicaid-eligible population (including Categorically Needy and Medically Needy beneficiaries); and, if otherwise required by section 1902(a)(10)(B), with respect to certain pharmacy and medical benefits, to provide benefits to some members of the TennCare Standard population that are not equal in amount, duration, and scope to benefits available to certain Medicaid-eligible groups.

   To enable the State to modify the Medicaid benefit package to: a) offer a different benefit package than would otherwise be required under the State plan; b) offer benefits for such individuals without offering the same coverage to the non-demonstration population; and c) limit benefits offered to individuals who elect the TennCare Assist program to payment of part or all of the cost of coverage under a group health plan.

2. **Freedom of Choice** **Section 1902(a)(23)**

   To enable the State to restrict free choice of providers for Medicaid services for individuals who are eligible for both Medicare and Medicaid.

   To enable the State to restrict freedom of choice of provider through the use of mandatory enrollment in managed care plans that would not be consistent with the requirements of section 1932 of the Act.

3. **Pharmacy Benefit Restrictions** **Section 1902(a)(54)**

To enable the State to eliminate coverage of benzodiazepines and barbiturates for adult TennCare enrollees.

4. **Methods of Administration** **Section 1902(a)(4)(A)**

To enable the State to have only one Behavioral Health Organization (BHO) to provide behavioral health services in a region of the State or statewide.

5. **Uniformity** **Section 1902(a)(1)**

To enable the State to provide certain types of managed care plans only in certain geographical areas of the State and to permit non-demonstration populations (e.g., those requiring long-term care) to receive current Medicaid benefits, whereas demonstration recipients will receive modified services.

6. **Eligibility** **Section 1902(a)(34)**

To enable the State to waive the requirement to provide medical assistance for up to 3 months prior to the date that an application for assistance is made.

7. **Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Benefit** **Section 1902(a)(10)**

To enable the State to permit managed care contractors to limit coverage of FQHC and RHC services when CMS and the State have determined that equivalent services are available and accessible in other covered settings.

8. **Disproportionate Share Hospital Payments** **Section 1902(a)(13)(A)**

To relieve the State from the obligation to make payments for inpatient hospital services that take into account the situation of hospitals with a disproportionate share of low-income patients.

9. **Payment for Drugs** **Section 1902(a)(54)**

To enable the State to permit managed care contractors to establish drug formularies based on cost, therapeutic equivalent, and clinical efficacy.

10. **Indirect Payment** **Section 1902(a)(32)**

To enable the State to pay indirectly for covered benefits through a group health plan that meets requirements set by the State and approved by CMS.

11. **Comparability of Eligibility** **Section 1902(a)(17)**

To enable the State to close enrollment for the Aged, Blind, Disabled, and Caretaker Relative Medically Needy categories only, as defined in the State plan, who are age 21 or older and not pregnant, until the completion of eligibility redetermination and termination of individuals currently enrolled in these medically needy categories prior to and upon the end of their current eligibility periods.

12. **Simplicity of Administration** **Section 1902(a)(19)**

To enable the State to close enrollment for the Aged, Blind, Disabled, and Caretaker Relative Medically Needy categories only, as defined in the State plan, who are age 21 or older and not pregnant, until the completion of eligibility redetermination and termination of individuals currently enrolled in these medically needy categories prior to and upon the end of their current eligibility periods.

13. **Description of Eligibility for Categories of Medically Needy** **Section 1902(a)(10)(C)**

To enable the State to close enrollment for the Aged, Blind, Disabled, and Caretaker Relative Medically Needy categories only, as defined in the State plan, who are age 21 or older and not pregnant, until the completion of eligibility redetermination and termination of individuals currently enrolled in these medically needy categories prior to and upon the end of their current eligibility periods.

14. **Eligibility for all Individuals Described in State Plan** **Section 1902(a)(8)**

To enable the State to close enrollment for the Aged, Blind, Disabled, and Caretaker Relative Medically Needy categories only, as defined in the State plan, who are age 21 or older and not pregnant, until the completion of eligibility redetermination and termination of individuals currently enrolled in these medically needy categories prior to and upon the end of their current eligibility periods.

15. **Comparability** **Section 1902(a)(10)(C)**
Section 1902(a)(17)

To enable the State to establish exceptions and exclusions of otherwise applicable pharmacy benefit limits and coverage restrictions for some members of Medicaid-eligible groups while applying such limits to other members of those groups.

Specific Rules Applicable to the TennCare Standard Demonstration Population

Because the TennCare Standard population is not covered under Tennessee's approved State plan for medical assistance or subject to the rules of the Medicaid statute and regulations, the requirements of the statute and regulations only apply to them by virtue of the approval documents (including the STCs contained in those documents). In order to permit the demonstration project to function as amended, in addition to and/or consistent with previously approved waiver and expenditure authority, the following Medicaid requirements will not apply to the TennCare Standard demonstration population:

Continuous Enrollment **Section 1902(a)(8)**

To permit the State to redetermine eligibility and disenroll members of the demonstration population pursuant to the process described in Attachment E of the enclosed STCs.

Amount, Duration, and Scope **Section 1902(a)(10)(B)**

To enable the State to offer demonstration enrollees benefits that are not equal in amount, duration, and scope to benefits available to other TennCare enrollees and Medicaid recipients, and to provide a different amount, duration, and scope of benefits or coverage to some segments of the demonstration population than the State provides to other segments of that population.

Pharmacy Benefit Restrictions **Section 1902(a)(54)**

To enable the State to eliminate coverage of outpatient drugs from the benefits package provided to non-Standard Spend Down adult members of the demonstration population, including both over the counter and prescription medications.

CENTERS FOR MEDICARE AND MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBERS: **No. 11-W-00151/4**

TITLE: **TennCare Medicaid Section 1115 Demonstration**

AWARDEE: **Tennessee Department of Finance and Administration**

Expenditure Authorities

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the State for the items identified below, which are not otherwise included as expenditures under section 1903, shall, for the period of this demonstration extension, be regarded as expenditures under the State's title XIX plan.

The following costs not otherwise matchable expenditure authorities shall enable the State to implement the approved special terms and conditions (STCs) for the Tennessee section 1115 demonstration (TennCare) amendments.

1. Under the authority of section 1115(a)(2) of the Act, expenditures made by the State to provide services identified in the STCs to children under age 21 who are enrolled in the TennCare Standard program shall, for the period of the amended project, be regarded for purposes of receiving Federal financial participation, as expenditures under the State's title XIX plan. This authority is consistent with and/or in addition to the expenditure authority granted in previously approved amendments to the TennCare demonstration project. All requirements of the Medicaid statute will be applicable to such expenditures, except those previously waived or specifically waived or otherwise addressed in this letter or in the accompanying STCs. In addition, all requirements in the enclosed STCs will apply to this expenditure authority.

2. Expenditure for enrollees in the TennCare Assist program who would otherwise be eligible in one of the categories above (whose benefits under this demonstration will be limited to employee health insurance subsidy payments).

3. Expenditures under contracts that do not meet the requirements in section 1903(m) of the Act specified below. Specifically, Tennessee managed care plans will be required to meet all requirements of section 1903(m) except the following:

- Section 1903(m)(2)(A)(vi), Federal regulations at 42 CFR 438.56, to the extent that the rules in section 1932(a)(4) incorporated therein are inconsistent with the enrollment and disenrollment rules under the demonstration such as restricting an enrollee's right to disenroll within 90 days of enrollment in a new managed care organization (MCO). Enrollees may change MCOs once within the first year of enrollment, and annually thereafter, except that during initial transition enrollment, enrollees may be limited to one change during the first enrollment period which may be less than 12 months but no less than 6 months.

4. Expenditures for services to a TennCare enrollee residing in an institution for mental disease for the first 30 days of an inpatient episode, subject to an aggregate annual limit of 60 days and other limitations specified in the STCs. *Note: This expenditure authority was withdrawn, except to the extent it has been agreed upon and is outlined in the STC Attachment D.5.e, because the Centers for Medicare & Medicaid Services (CMS) has determined that it would not promote the objectives of title XIX.*

5. Expenditures for the following demonstration populations which would not be eligible under the approved State plan. These populations may be automatically disenrolled after a year, in the absence of a reapplication and redetermination of eligibility:
   - Individuals under age 19 who are uninsured and meet the State-defined criteria as "medically eligible;"
   - Individuals under age 19 who are uninsured with family incomes at or below 200 percent of the Federal poverty level;
   - Individuals under age 19, with family incomes at or below 200 percent of the FPL, who were enrolled in the previous demonstration as of December 31, 2001, under the category of "uninsured who had access to insurance;" and
   - Individuals under age 19 and who have Medicare coverage but not Medicaid coverage, were enrolled in the previous demonstration as of December 31, 2001, and continue to meet the criteria for "Uninsurable" that were in place December 31, 2001.

6. Pending their eligibility redetermination and disenrollment, individuals who are:

   ➢ Eligible as Medically Needy Aged, Blind, Disabled, and Caretaker Relatives;

- Age 19 and older who are uninsured and meet the State-defined criteria as "medically eligible;"
- Age 19 and older who are uninsured with family incomes at or below 200 percent of the FPL; and
- Age 19 and older who have Medicare coverage but not Medicaid coverage, were enrolled in the previous demonstration as of December 31, 2001, and continue to meet the criteria for "Uninsurable" that were in place at that time.

7. Expenditures for the State in the amount of $50 million total computable dollars for special hospital pool payments for the period of demonstration year #04 (i.e., State fiscal year 2006) to pay for un-reimbursed costs of care in hospitals. This authority is a one-time allotment.

8. Expenditures for non-pregnant adults over age 21 who meet eligibility criteria for "TennCare Standard Spend Down" demonstration category, who would not be eligible under the State plan.

CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00151/4

TITLE: Tennessee TennCare Demonstration Project

AWARDEE: Tennessee Department of Finance and Administration

The following are the special terms and conditions (STCs) for Tennessee's section 1115 Health Care Reform Demonstration (TennCare). The parties to this agreement are the Tennessee Department of Finance and Administration (State) and the Centers for Medicare & Medicaid Services (CMS). These terms and conditions have been modified to include amendments the State submitted to CMS on September 24, 2004, February 18, 2005, January 11, 2006, and April 3, 2006, and the clarification letters of May 17, 2006, and May 31, 2006. The STCs set forth below and the lists of waivers and expenditure authorities are incorporated in their entirety into the letter approving the amended demonstration. All previously granted waiver and expenditure authorities are superseded by these STCs and the Waiver and Expenditure Authorities lists.

1. Upon the approval date of the August 8,2006, revision to these STCs, the State may establish a new TennCare Standard Spend Down (SSD) demonstration expansion group. The State shall impose an enrollment cap of 105,000 on the SSD program, with targeted enrollment of 100,000. The process for enrollment into the SSD program shall be developed by the State, and comply with applicable Federal statutes and regulations and Attachment H. The process for disenrollment of non-pregnant Medically Needy adult beneficiaries described in Attachment E, shall be initiated by one year following the approval of the demonstration amendment. Adult TennCare Standard enrollees other than enrollees in the SSD program shall not be eligible to receive outpatient pharmacy benefits. All TennCare Standard enrollees are not eligible for long term care services, including services in a nursing facility or institutional care facility for the mentally retarded (ICF/MR), or home and community based waiver services. TennCare Standard enrollees who are dually eligible for Medicare receive coverage for the same Medicare cost-sharing obligations that are available for Medically Needy pregnant women and children enrolled through the State Plan. SSD enrollees are not subject to TennCare Standard cost sharing requirements but

do have nominal co-payments for pharmacy benefits on the same terms as adult Medicaid enrollees.

2. Upon the approval date of the August 8, 2006, revision to these STCs, the State may develop and maintain a list of drugs that may be approved for enrollees who have already met an applicable benefit limit only if the prescribing professional seeks and obtains a special exemption. The State may include certain drugs or categories of drugs on the list, and may maintain, and make available to physicians, providers, pharmacists, and the public, a list that shall indicate the drugs or types of drugs the State has determined to so include. In order to obtain a special exemption, the prescribing provider must submit an attestation as directed by TennCare regarding the urgent need for the drug. TennCare will approve the prescribing provider's determination that the criteria for the special exemption are met, without further review, within 24 hours of receipt. Enrollees will not be entitled to a hearing regarding their eligibility for a special exemption if (i) the prescribing provider has not submitted the required attestation or (ii) the requested drug is not on the special exemption list.

3. Effective January 1, 2006, the State may exclude benzodiazepines and barbiturates from the pharmacy benefit provided to TennCare Medicaid adults. Benzodiazepines and barbiturates will remain available to all TennCare enrollees under age 21 to the extent that they are medically necessary.

4. Upon the approval date of the March 17, 2006, revision to these STCs, this demonstration project amendment, the State may re-establish an annual managed care organization (MCO) change period, accomplished through a balloting process which will occur in the fall of each year. Changes will be effective on January 1 of the following year.

5. Upon the approval date of the March 17, 2006, revision to these STCs, the State may have only one behavioral health organization (BHO) operate in each of the three grand regions of the State identified in the application or statewide. The State shall ensure continued access to choice of providers within the BHO.

6. As of January 1, 2006, individuals who are eligible for both Medicaid and Medicare will be transferred from the existing 1915(b) waiver into the section 1115 demonstration. The TennCare 1915(b) waiver shall be terminated upon implementation of this authority.

7. Upon the June 8, 2005, demonstration amendment and the approval date of the March 17, 2006, revision to these STCs, the State may implement the notice and appeals processes summarized in Attachment F.

8. During demonstration year (DY) #04 (i.e., State fiscal year (SFY) 2006), the State shall have the one-time authority to pay a $50 million special hospital pool payment. This authority is granted only for DY #04, and is not withstanding previously granted authorities and STCs. All expenditures claimed for Federal financial participation (FFP) from this $50 million special hospital pool will be subject to budget neutrality limits described in Attachment B to the STCs. Actual cash disbursements will be subject to financial requirements described in Attachment D to the STCs. The special hospital pool distribution methodology described in Attachment G to the STCs shall be used in distributing this one-time, $50 million total computable pool.

9. Under the demonstration amendment granted by CMS, the State possesses the authority to close enrollment (including rollover enrollment from other TennCare Medicaid and TennCare Standard categories), terminate coverage, and disenroll individuals in the following demonstration eligibility categories, pursuant to the process outlined in Attachment E:

    - Individuals age 19 and older who are uninsured and meet the State-defined criteria of "medically eligible;"

    - Individuals age 19 and older who are uninsured with family income at or below 200 percent of the Federal poverty level (FPL); and

    - Individuals age 19 and older who have Medicare coverage but not Medicaid coverage, were enrolled in the previous demonstration as of December 31, 2001, and continue to meet the criteria for "Uninsurable" that were in place on December 31, 2001.

10. Under the demonstration amendment granted by CMS, the State possesses the authority to close enrollment into the following demonstration eligibility categories:

    - Individuals under age 19 who are uninsured, meet the State-defined criteria of "medically eligible," and have incomes that are below 100 percent of the FPL; and

    - Individuals under age 19 who are uninsured with family incomes at or below 200 percent of the FPL.

    Individuals under age 19 who lose eligibility for Medicaid or a TennCare Standard category may continue to roll over into TennCare Standard categories if they meet the criteria for such categories, until such time as the State notifies CMS of any changes to this policy.

11. Upon the effective date of this demonstration project amendment, the State has the authority to close TennCare Medicaid enrollment for the eligibility categories Aged, Blind, Disabled, and Caretaker Relative Medically Needy who are age 21 or older and are not pregnant. Individuals already enrolled in this eligibility category shall remain eligible for TennCare Medicaid coverage for the remainder of their Medically Needy eligibility period. Prior to termination of the applicable individual eligibility period, the State will redetermine eligibility of these individuals. At the end of the applicable individual eligibility periods, the State will terminate those individuals not found eligible for open Medicaid categories pursuant to the process summarized in Attachment E, and in compliance with this amendment and Federal regulations at 42 CFR Part 431 Subpart E. At the conclusion of this process, and upon approval of a State plan amendment, Tennessee will eliminate Medicaid coverage for the optional Aged, Blind, Disabled, and Caretaker Relative Medically Needy eligibility categories.

12. Adult TennCare Standard enrollees other than enrollees in the SSD program are not eligible to receive outpatient pharmacy benefits.

13. Outpatient pharmacy coverage for adult Medicaid and SSD recipients eligible for such benefits will be limited to five prescriptions per month, except when drugs are prescribed for enrollees receiving services in nursing facilities, in ICF/MRs, or under a Home and Community Based Services (HCBS) waiver. Of the five covered prescriptions allowed per month, no more than two covered prescriptions may be for brand name drugs, and at least three of any five covered prescriptions must be for generic drugs. Brand name drugs that are not on the State's Preferred Drug List will be subject to a prior authorization requirement, in addition to the monthly limitation on the number of covered prescriptions for brand name drugs, and the State will designate the drugs for which prior authorization will be required as a condition of coverage or payment.

    Outpatient pharmacy benefit limits do not apply to children under age 21 enrolled in either TennCare Medicaid or TennCare Standard.

14. The State may exclude certain drugs or categories of drugs from the five prescription pharmacy benefit limit, and shall maintain, and make available to physicians, providers, pharmacists, and the public, a list that shall indicate the drugs or types of drugs the State has determined to so exclude.

15. A prescribed outpatient drug that is available over-the-counter will be available as a covered service only when medically necessary for an eligible Medicaid or TennCare Standard enrollee under the age of 21, or in the case of prenatal vitamins (including folic acid) prescribed for a pregnant woman.

16. In an emergency situation, up to a 72-hour supply of a drug requiring prior authorization as a condition of coverage shall be dispensed on a covered basis to an enrollee who presents a pharmacist with a prescription for which prior authorization is required but has not yet been obtained. Such emergency supply shall be available only once with respect to any particular prescription, and shall not be available on a covered basis where the dispensing pharmacist determines that a request for prior authorization of the prescribed drug and dosage has previously been denied for the same enrollee. For purposes of implementation of this policy, the State shall define an emergency situation as a situation that, in the judgment of the dispensing pharmacist, involves an immediate threat of severe adverse consequences to the enrollee, or the continuation of immediate and severe adverse consequences to the enrollee, if an outpatient drug is not dispensed when a prescription is submitted.

17. Adults in TennCare Medicaid and TennCare Standard will not be eligible to receive dental services as covered services. Dental services will be covered as required under Federal Early & Periodic Screening, Diagnosis & Treatment (EPSDT) Program requirements for TennCare Medicaid enrollees under age 21 or as medically necessary for TennCare Standard enrollees under age 21.

18. Adults in TennCare Medicaid and TennCare Standard will not be eligible to receive Methadone Clinic services as covered services. Methadone Clinic services will be covered as required under Federal EPSDT Program (or Services) requirements for TennCare Medicaid enrollees under age 21, or as medically necessary for TennCare Standard enrollees under age 21.

19. The State will implement previously approved authority to limit substance abuse services to $30,000 in lifetime benefits for all adult TennCare Medicaid and TennCare Standard enrollees age 21 and older, regardless of whether or not the enrollee has been designated as seriously and persistently mentally ill.

20. Upon the effective date of this demonstration project amendment, the State has the authority to remove any out-of-pocket (OOP) maximums applied to cost-sharing obligations for TennCare Standard enrollees. OOP maximums will also not be applicable to the nominal cost-sharing obligations of TennCare Medicaid enrollees with respect to outpatient pharmacy services.

21. The State will impose a standard nominal co-payment requirement upon eligible adult recipients of TennCare pharmacy services consisting of brand name prescription drugs, as well as upon TennCare Standard enrollees under the age of 21 in families with income at or above 100 percent of the FPL. These enrollees will be charged a standard co-payment of $3.00 per prescription or refill of any covered, outpatient, brand name drug. The State will not impose any co-payment requirement upon an enrollee's receipt of a covered generic drug. The State's co-payment requirements for brand name pharmacy services to adult TennCare Medicaid enrollees will not apply under

the circumstances identified in Section 1916 of the Social Security Act (the Act) and Federal regulations at 42 CFR section 447.53(b), or to services received by enrollees who receive services under an HCBS waiver. With respect to pharmacy services for Tenncare Standard enrollees under the age of 21 in families with income at or above 100 percent of the FPL, such individuals will be exempted from the co-payment requirements only to the extent that a Medicaid eligible adult would have been exempt from those requirements (i.e., for family planning services and supplies for an enrollee of child-bearing age, emergency services as defined by section 447.53(b)(4), services to institutionalized individuals, services to pregnant women related to the pregnancy or a condition that could complicate the pregnancy, or services to an individual who is receiving hospice care). Medicaid-eligible children under the age of 21 and TennCare Standard enrollees under the age of 21 in families with income below 100 percent of the FPL will not be subject to co-payment requirements when receiving covered outpatient pharmacy services.

22. All contracts and modifications of existing contracts between the State and MCOs or BHOs must be approved by CMS prior to the effective date of the contract or modification of an existing contract. In addition, for any contract in which there exists a clause allowing cost effective alternatives, alternative services that were not included in the list submitted by the State to CMS on April 11, 1996, must be approved in advance by CMS. No FFP will be available for any contract, modification, or services not approved by CMS in advance of its effective date, or, in the case of services, the date of use. Within 30 days of the receipt of a complete and final document, CMS will either approve the document or notify the State of issues that will require additional discussion.

23. The State shall prepare one Operational Protocol document that represents the policy and operating provisions applicable to this demonstration which have been agreed to by the State and CMS. The State must submit this protocol to CMS no later than 90 days after implementation. CMS will respond within 45 days of receipt of the protocol. If CMS requires any changes to the initial Operational Protocol, the State will discuss required revisions with CMS and develop revisions acceptable to CMS within 45 days thereafter. During the demonstration, the State is required to update the operational protocol to reflect any major changes in policy or operating procedures that were the result of a waiver amendment approval, and to inform CMS that such updates have been made to the protocol by submitting to CMS replacement pages for the CMS copy of the protocol. Demonstration amendments are required for any major changes in policy or operating procedures in the following areas: eligibility, enrollment, benefits, delivery systems, cost sharing, evaluation design, FFP, budget neutrality, and other comparable program elements. The State is also required to update its operational protocol to reflect changes that have occurred in policy or operating procedures that did not require demonstration amendments, and to inform CMS that such updates have been

made to the protocol by submitting to CMS replacement pages for the CMS copy of the protocol. Upon any subsequent renewal of the demonstration, CMS will incorporate the necessary provisions of the Operational Protocol into the STCs, thus eliminating the need for an Operational Protocol document. The STCs include information and requirements which shall be included in the protocol, as set forth in Attachment A.

24. Not later than 90 days prior to implementation of an employer-sponsored health insurance subsidy program, the State shall submit an addendum to the Operational Protocol describing how the program will operate, how the phase-in process will progress, and how the State will monitor the program to assure that covered employer-sponsored programs meet all requirements for participation in the program. The addendum must be reviewed and approved by CMS prior to implementation.

25. The State will conduct beneficiary surveys each operational year of the demonstration. The State shall conduct a statistically valid sample survey of all TennCare enrollees. The survey will measure satisfaction and include measures of out-of-plan use, average waiting time for physician office visits, and the number and causes of disenrollment. Results of the survey and an electronic file containing the raw data collected must be provided to CMS by the ninth month of each operational year. Within 30 days of the receipt of a complete and final document, CMS will either approve the document or notify the State of issues that will require additional discussion.

26. The State shall require all providers to submit data as defined in the minimum data set submitted to CMS in project year one. The State must perform periodic reviews, including validation studies, in order to ensure compliance. The State shall have provisions in its contracts with health plans to provide the data and be authorized to impose financial penalties if accurate data are not submitted in a timely fashion. If the State fails to provide accurate and complete encounter data for any managed care plan, it will be responsible for providing to the designated CMS evaluator data abstracted from medical records comparable to the data which would be available from encounter reporting requirements.

27. At a minimum, the State's plan for using encounter data to pursue health care quality improvement must focus on the following priority areas:

    - Childhood immunizations
    - Prenatal care and birth outcomes
    - Pediatric asthma
    - Two additional clinical conditions to be determined by the State based upon the population(s) served

28. The State must fully meet the Medicaid disclosure requirements specified by Federal regulations at 42 CFR Part 455, Subpart B, for contracting with MCOs.

29. The State shall require health plans to contract with Federally Qualified Health Centers (FQHCs). If FQHCs implement their own managed care plan, other managed care plans in the same service area will not be required to contract with FQHCs. If a managed care plan can demonstrate to CMS and to the Tennessee Department of Human Services that both adequate capacity and an appropriate range of services for vulnerable populations exists to serve the expected enrollment in a service area without contracting with FQHCs, the plan can be relieved of this requirement.

30. The State must develop internal and external audits to monitor the performance of the plans. At a minimum, the State shall monitor the financial performance and quality assurance activities of each plan. Upon request, the State will submit to the Project Officer and to the CMS Regional Office copies of all financial audits of participating health plans and quality assessment reviews of these plans.

31. The allowable disbursements from the supplemental pools described in General Financial Requirements Under Title XIX (Attachment D), items 5.b and 5.c, are limited to the categories and amounts disbursed in SFY 2002, except that the Essential Access Hospital supplemental pool is limited to $100 million in each DY and the Critical Access Hospital supplemental pool is limited to $10 million in each DY. The State may request approval to make disbursements from the supplemental pools in excess of the amounts disbursed in SFY 2002. The State must submit a request to change supplemental funding pools which details proposed changes and includes the State's intention to begin or end payments from these pools. The request must include a specific description of the source of pool funds, how payment amounts will be determined, how payments will be made, and what audit trail will exist. The State will not make payments from a supplemental pool until CMS has approved the supplemental pool payment methodology change and documentation. CMS reserves the right to deny approval of increases to payments from supplemental pools, even if approval would not compromise budget neutrality.

    The State will certify State/local monies used as matching funds for the demonstration and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by law. All sources of the non-Federal share of funding and distribution of monies involving Federal match are subject to CMS approval. Any amendments that impact the financial status of the program will require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

32. The State shall comply with all requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the award letter of which these terms and conditions are part. In addition, the State shall, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid program that occur after July 1, 2002, to the extent that the changes are applicable to programs being operated under section 1115 demonstration authority. This requirement shall also apply to all applicable regulation and policy issued by CMS with respect to the Deficit Reduction Act of 2005, signed into law on February 8, 2006, including, but not limited to, the documentation of citizenship requirements contained in section 1137(d),10903(i)(22), and 1903(x) of the Act. If the changes require either a reduction or an increase in FFP in expenditures under such a demonstration, the State will adopt, subject to CMS approval, modified budget limits for TennCare as necessary to comply with such change. The modified budget limit would be effective upon the implementation of the change.

33. The State must maintain and update eligibility data to allow hospitals to accurately distinguish individuals who are eligible for Medicaid under the State plan from individuals who are only eligible because of the demonstration.

34. The State will submit quarterly progress reports, which are due 60 days after the end of each quarter. The reports should include a discussion of events occurring during the quarter that affect health care delivery, quality of care, access, financial results, benefit package, and other operational issues. The report should include a separate discussion of State efforts related to the collection and verification of encounter data. The report should also include proposals for addressing any problems identified in the quarterly report. Utilization of health services based on encounter data should be reported on a quarterly and cumulative basis by health plan. At a minimum, this should include physician visits, hospital admissions, and hospital days per 1,000 member months, broken out by pregnant women, other adults, and children.

35. The State will submit a draft annual report, documenting accomplishments, project status, quantitative and case study findings, and policy and administrative difficulties no later than 120 days after the end of each calendar year of operation. Within 30 days of receipt of comments from CMS, a final annual report will be submitted.

36. During the last 6 months of the demonstration, no enrollment of individuals who would not be eligible under current law will be permitted.

37. Tennessee will implement modifications to the demonstration by submitting revisions to the original proposal for CMS approval. The State shall not

submit amendments to the approved State plan relating to the expansion populations.

38. The State must continue to ensure that an adequate Medicaid Management Information System is in place and provide evidence of such to CMS upon request. One feature of the system must be to report current enrollment by plan and Medicaid eligibility group.

39. The State must assure that its eligibility determinations are accurate.

40. The CMS project officer or designee will be available for technical consultation at the convenience of the awardee within 5 working days of telephone calls and within 10 working days on progress reports and other written documents submitted. The State will be similarly available for consultation with CMS.

41. A draft final report should be submitted to the CMS project officer for comments. CMS comments should be taken into consideration by the awardee for incorporation into the final report. The final report is due no later than 90 days after the termination of the project.

42. The CMS may suspend or terminate any project in whole, or in part, at any time before the date of expiration, whenever it determines that the awardee has materially failed to comply with the terms of the project. CMS will promptly notify the awardee in writing of the determination and the reasons for the suspension or termination, together with the effective date. CMS reserves the right to withdraw waivers at any time if it determines that continuing the waivers would no longer be in the public interest. If a waiver is withdrawn, CMS will be liable for only normal closeout costs.

43. The awardee shall assume responsibility for the accuracy and completeness of the information contained in all technical documents and reports submitted.

44. The awardee shall develop and submit detailed plans to protect the confidentiality of all project-related information that identifies individuals. The plan must specify that such information is confidential, that it may not be disclosed directly or indirectly, except for purposes directly connected with the conduct of the project, and that informed written consent of the individual must be obtained for any disclosure.

45. At any phase of the project, including at the project's conclusion, the awardee, if so requested by the project officer, must submit to CMS analytic data file(s), with appropriate documentation, representing the data developed/used in end-product analyses generated under the award. The analytic file(s) may include primary data collected, acquired, or generated under the award and/or data furnished by CMS. The content, format, documentation, and schedule

for production of the data file(s) will be agreed upon by the principal investigator and the CMS project officer. The negotiated format(s) could include both file(s) that would be limited to CMS internal use and file(s) that CMS could make available to the general public.

46. At any phase of the project, including at the project's conclusion, the awardee, if so requested by the project officer, must deliver to CMS any materials, systems, or other items developed, refined, or enhanced in the course of, or under, the award. The awardee agrees that CMS shall have royalty-free, nonexclusive, and irrevocable rights to reproduce, publish, or otherwise use and authorize others to use the items for Federal Government purposes.

47. Prior to the start date of delivery of services by any MCO or BHO in any area of the State, the State must submit evidence that the MCOs capacity is adequate in that area of the State to serve the expected enrollment. CMS will base its evaluation of adequacy on the access standards in Attachment C. Copies of the individual provider agreements with the MCOs shall be provided to CMS upon request.

48. The State and CMS will develop a modified budget limit in preparation for the implementation of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, effective January 1, 2006. By September 30, 2005, the State will develop a tracking and identification methodology for all persons under the demonstration who are eligible for Medicare Part D. After December 31, 2005, no duplication of coverage of the Part D benefits will be provided under this demonstration.

49. The State may suspend or terminate this demonstration in whole or in part at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase-out the demonstration, the State and CMS will collaborate on the phase-out plan. The State shall submit a phase-out plan to CMS at least 6 months prior to initiating phase-out activities. The State may also submit an extension plan on a timely basis to prevent disenrollment of demonstration enrollees. Nothing herein shall be construed as preventing the State from submitting a phase-out-plan with an implementation deadline shorter than 6 months when such action is necessitated by emergent circumstances. The phase-out-plan and extension plan are subject to CMS approval. If the project is terminated or any relevant waivers suspended by the State, FFP shall be available for only normal closeout costs associated with terminating the demonstration, including services and administrative costs of disenrolling participants.

50. If the State intends to extend the demonstration beyond the period of approval granted, then the State is responsible for reviewing, complying, and adhering to the timeframes and reporting requirements as stated in section 1115(e) and section 1115(f) of the Act.

Attachment A

TennCare
Outline for Operational Protocol

Tennessee will be responsible for developing a detailed protocol describing the Tennessee section 1115 demonstration (TennCare) demonstration to the extent not otherwise addressed or amended in the Special Terms and Conditions (STCs) or amendments thereto. The protocol is a stand-alone document that reflects the operating policies and administrative guidelines of the demonstration. The State shall assure and monitor compliance with the protocol. Areas that should be addressed in the document include:

1. Organizational and structural configuration of the demonstration arrangements
2. Organization of managed care networks
3. Payment mechanism
4. Benefit packages
5. TennCare eligibility process
6. Marketing and outreach strategy
7. Enrollment process
8. Quality assurance and utilization review system
9. Grievance and appeal policies
10. Administrative and management system
11. Encounter data
12. Federally qualified health centers
13. Financial reporting
14. Eligibility criteria

15 Cost sharing

Attachment B

Monitoring Budget Neutrality for the TennCare Demonstration

The following describes the method by which budget neutrality will be assured under Tennessee's section 1115 Health Care Reform demonstration (TennCare) beginning July 1, 2002. In general, Tennessee will be using a per capita cost method, and TennCare budget targets will be set on a yearly basis, with a cumulative 5-year budget limit.

Individuals who are eligible under TennCare will be one of three types: (1) those who are currently eligible under Tennessee's existing Medicaid State plan; (2) those who could be eligible for Medicaid if Tennessee amended its State plan; and (3) those who could not be eligible without section 1115 authority. Tennessee will be at risk for the per capita cost (as determined by the method described below) for current eligibles (as defined by groups 1 and 2 above) but not at risk for the number of current eligibles. By providing Federal financial participation (FFP) for all current eligibles, Tennessee will not be at risk for changing economic conditions. However, by placing Tennessee at risk for the per capita costs for current eligibles, the Centers for Medicare & Medicaid Services (CMS) assures that TennCare expenditures do not exceed the level of expenditures had there been no demonstration project. Tennessee will be at risk for both enrollment and expenditure growth for demonstration eligibles who could not be eligible without section 1115 authority (as defined by group 3 above).

Each demonstration year (DY) expenditure target for TennCare will be the sum of two budget components: (A) the projected cost of services by specified MEGs; and (B) the projected Disproportionate Share Hospital (DSH) adjustment. Each of these components has a distinct method for projecting costs into the future. Administrative costs under the demonstration will be excluded from the budget neutrality formula except as explained in Attachment D.

There are two steps involved in the calculation of the projected cost of services (A above) budget limit: (1) determining baseline estimates of the number of Medicaid eligibles and the cost per eligible; and (2) determining the method for inflating these estimates over time.

For the Children, Disabled, Adults over 65, and Other Adults MEGs, the initial per capita cost estimate was based on the 1992 per capita costs of Medicaid eligibles, inflated to reflect State fiscal year (SFY) 2002 expenditures. That amount was trended to cover SFY 2003 using the National Medicaid Health Expenditures trend rate. The 1992 and SFY 2003 monthly per member per month (PMPM) amounts for these groups and the specific growth rates for the PMPM amounts for the remaining 4 years of the demonstration are listed in the table below. Effective beginning January 1, 2006, a fifth MEG named "Duals," which represents the population of individuals who are eligible for both Medicaid and Medicare which transitioned into TennCare from the former 1915(b) Freedom of Choice waiver, will be added to the calculation of the projected cost of services (A above) budget limit. Instead of inflating the 1992 per capita expenditures for this MEG to the present, a base PMPM was calculated for this MEG using the actual 1915(b) waiver expenditures for SFY 2005 . The SFY 2005 base PMPM for the Duals shall be trended forward only for the final 2 years of TennCare as listed in the table below.

	PMPM Expenditures		Annual Demonstration Trend Rates			
MEGs	**SFY 1992**	**SFY 2003/ DY-1**	**SFY 2004/ DY-2**	**SFY 2005/ DY-3**	**SFY 2006/ DY-4**	**SFY 2007/ DY-5**
Children	$ 107.07	$ 230.19	7.98%	7.98%	7.98%	7.98%
Disabled	$ 339.57	$ 730.05	7.84%	7.84%	7.84%	7.84%
Over 65	$ 147.75	$ 317.64	6.18%	6.18%	6.18%	6.18%
Adults	$ 211.68	$ 455.09	7.75%	7.75%	7.75%	7.75%
	SFY 2005					
Duals	$ 77.01				8.0%	8.0%

The annual limit on Medicaid expenditures will be the sum of the DSH adjustment for that year and the products of the inflated PMPM cost estimates for that year times the number of the enrollees' member months for each of the MEGs, which shall be limited to those who would have been Medicaid eligible without the demonstration, including optional populations that could have been authorized under State plan amendments.

The DSH adjustment is based on DSH payments made by Tennessee in 1992 and calculated in accordance with current law. The DSH adjustment for the initial year of the demonstration (i.e., SFY 2003) is $413,700,907. The DSH adjustment for each subsequent year shall be the previous DY's adjustment trended by the consumer price index for urban areas (CPI-U) for that year, as published 3 months after the end of the DY. In this manner, Tennessee will have available funding for DSH adjustments similar to other States. The calculation of the DSH adjustment will be appropriately adjusted if Congress enacts legislation which impacts the calculation of DSH allotments.

The CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through letters, memorandums, or regulation with respect to the provision of services covered under TennCare. CMS reserves the right to make adjustments to the budget neutrality cap if any health care-related tax that was in effect during the base year with respect to the provision of services covered under this demonstration, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care-related tax provisions of section 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

Budget neutrality will be determined over a 5-year period. Any annual savings from budget neutrality may only be applied to an eligibility expansion or to offset demonstration costs in excess of the annual budget limits during this period. The State must submit for CMS approval a waiver amendment requesting the expansion. In its amendment, the State must demonstrate that the expansion is sustainable, even when the accrued savings from this 5-year demonstration period are exhausted.

The CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, no later than 6 months after the end of an individual DY, Tennessee will calculate annual expenditure targets for the completed year for each of the demonstration components. The annual component targets will be summed to calculate a target annual spending limit. This amount should be compared with the actual amount claimed for FFP. Using the below schedule as a guide, if Tennessee exceeds these targets they shall submit a corrective action plan to CMS for approval.

Year	Cumulative target definition	Percentage
Year 1	Year 1 budget neutrality cap plus	8 percent
Year 2	Years 1 and 2 combined budget neutrality cap plus	3 percent
Year 3	Years 1 through 3 combined budget neutrality cap plus	1 percent
Year 4	Years 1 through 4 combined budget neutrality cap plus	0.5 percent
Year 5	Years 1 through 5 combined budget neutrality cap plus	0 percent

Attachment C

TennCare Access Standards

In general, contractors shall provide available, accessible, and adequate numbers of institutional facilities, service locations, service sites, professional, allied, and paramedical personnel for the provision of covered services, including all emergency services, on a 24-hour-a-day, 7-day-a-week basis. At a minimum this shall include:

Primary Care Physician or Extender:

(a) Distance/Time Rural: 30 miles or 30 minutes

(b) Distance/Time Urban: 20 miles or 30 minutes

(c) Patient Load: 2,500 or less for a physician; one-half this for a physician extender.

(d) Appointment/Waiting Times: Usual and customary practice (see definition below), not to exceed 3 weeks from the date of a patient's request for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.

(e) Documentation/Tracking requirements:

Documentation -- Plans must have a system in place to document appointment scheduling times. The State must utilize statistically valid sampling methods for monitoring compliance with appointment/waiting time standards as part of the survey required in special term and condition 25.

Tracking -- Plans must have a system in place to document the exchange of client information if a provider, other than the primary care provider (i.e., school-based clinic or health department clinic), provides health care.

Specialty Care and Emergency Care:

Referral appointment to specialists (e.g., specialty physician services, hospice care, home health care, substance abuse treatment, rehabilitation services, etc.) shall not exceed 30 days for routine care or 48 hours for urgent care. All emergency care is immediate, at the nearest facility available, regardless of contracts. Waiting times shall not exceed 45 minutes.

Hospitals:

Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where access time may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to the State on the basis of community standards.

General Dental Services:

Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where community standards and documentation will apply.

Appointment/Waiting Times: Usual and customary not to exceed 3 weeks for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.

General Optometry Services:

Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where community standards and documentation will apply.

Appointment/Waiting Times: Usual and customary not to exceed 3 weeks for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.

Pharmacy Services:

Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where community standards and documentation will apply.

Lab and X-Ray Services:

Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where community standards and documentation will apply.

Appointment/Waiting Times: Usual and customary not to exceed 3 weeks for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.

Other:

All other services not specified here shall meet the usual and customary standards for the community.

Definition of "Usual and Customary":

Access that is equal to or greater than the currently existing practice in the fee-for-service system.

Guidelines for State Monitoring of Plans

- The State will require, by contract, that Plans meet certain State-specified standards for Internal Quality Assurance Programs (QAPs) as required by Federal regulations at 42 CFR Part 434.

- The State will monitor, on a periodic or continuous basis (but no less often than every 12 months), plans' adherence to these standards, through the following mechanism: review of each plan's written QAP, review of numerical data and/or narrative reports describing clinical and related information on health services and outcomes, and on-site monitoring of the implementation of the QAP standards.

- Recipient access to care will be monitored through the following State activities: periodic comparison of the number and types of providers before and after the demonstration, periodic surveys which contain questions concerning recipient access to services, measurement of waiting periods to obtain health care services, and measurement of referral rates to specialists.

Guidelines for Plan Monitoring of Providers

- Plans will require, by contract, that providers meet specified standards as required by the State contract.

- Plans will monitor, on a periodic or continuous basis, providers' adherence to these standards, and recipient access to care.

Attachment D

General Financial Requirements Under Title XIX

1. The State will provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through Tennessee's section 1115 Health Care Reform demonstration (TennCare). This project is approved for expenditures applicable to services rendered during the demonstration period. The Centers for Medicare & Medicaid Services (CMS) will provide Federal financial participation (FFP) for allowable TennCare expenditures only so long as they do not exceed the pre-defined limits as specified in Attachment B (Monitoring Budget Neutrality for the TennCare Demonstration).

2. a. In order to track expenditures under TennCare, the State will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System, following the specific instructions contained in the Special Terms and Conditions (STCs), and the accompanying Attachments, along with the routine Form CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All TennCare expenditures subject to the budget neutrality cap will be reported on separate Form CMS-64.9 Waiver and/or 64.9P Waiver supporting schedules, identified by the project number assigned by CMS, including the project number extension, which indicates the demonstration year (DY) in which services were rendered or for which capitation payments were made. For TennCare expenditure monitoring purposes, any decreasing cost settlement adjustments attributable to the demonstration must be reported as prior period adjustments for Line 10B of the Summary Sheet, in lieu of Lines 9 or 10.C. For any other cost settlements (i.e., those not attributable to TennCare), the adjustments should be reported as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality cap," is defined below in item 6.

   b. For each DY, a Form CMS-64.9 Waiver and/or 64.9P Waiver supporting schedule will be submitted reporting expenditures subject to the budget neutrality cap. All expenditures subject to the budget neutrality ceiling for demonstration eligibles (current and expansion) must be reported. The sum of the expenditures, for all DYs reported during the quarter, will represent the expenditures subject to the budget neutrality limitations explained at Attachment B.

   c. Although the State agency administrative costs will not be included in the budget neutrality limit, the State must separately track and report additional administrative costs that are directly attributable to the demonstration. However, the administrative services portion of the amounts paid by the State to compensate any nonrisk contractors for their administration costs incurred in accordance with nonrisk contracts are considered to be costs of the demo that are subject to the budget neutrality limitations explained at Attachment B.

   d. All claims for expenditures subject to the budget neutrality cap (including any cost

settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the Form CMS-64 in order to properly account for these expenditures in determining budget neutrality.

e. The procedures related to this reporting process, report contents, and frequency must be discussed by the State in the Operational Protocol (see Attachment A).

3. a. For the purpose of calculating the budget neutrality expenditure cap described in Attachment B, the State must provide to CMS on a quarterly basis the actual number of eligible member/months for the Medicaid Eligibility Group (MEG) as defined in Attachment B for Group I – current eligibles and Group II – those who could be eligible for Medicaid if Tennessee amended its State plan. Member months will not be provided for Group III – those who could not be eligible for Medicaid without section 1115 authority. This information should be provided to CMS in conjunction with the quarterly progress report referred to in Item 34 of the STCs. If a quarter overlaps the end of one DY and the beginning of another, member/months pertaining to the first DY must be distinguished from those pertaining to the second. (DYs are defined as the years beginning on the implementation date, or the anniversary of that day.) Procedures for reporting eligible member/months must be defined in the Operational Protocol (see Attachment A).

b. The term "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member/months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member/months.

4. The standard Medicaid funding process will be used during the demonstration. The State must estimate matchable Medicaid expenditures on the quarterly Form CMS-37. As a supplement to the Form CMS-37, the State will provide updated estimates of expenditures subject to the budget neutrality cap as defined in 2.b. of this Attachment. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 Quarterly Expenditure Report, showing the expenditures made in the quarter just ended. CMS will reconcile expenditures reported on the quarterly Form CMS-64 reports with the Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State. The Forms CMS-37 and CMS-64 reports must clearly identify all categories of Medicaid and TennCare expenditures and revenues (i.e., cash managed care organization (MCO) and behavioral health organization (BHO) payments, supplemental pool payments, certified public expenditures (CPE), allowable institution for mental disease (IMD) costs, FFP reductions related to TennCare premium collections, etc.).

With regard only to hospital CPE described in 5.d. below, the State will report actual CPE within 12 months after the end of each fiscal yea (FY). At that time, the State will revise its FFP claim to reconcile actual CPEs with the CPE estimates used during the preceding FY.

5. The CMS will provide FFP at the applicable Federal matching rates for the following approved TennCare expenditures, provided the State funds the non-Federal share from permissible funding sources, subject to budget neutrality limits explained in Attachment B.

    a. The actual cash payments made by the State for TennCare covered services provided through managed care contractors for each TennCare enrollee can generally be claimed by the State as a medical assistance payments at the Federal medical assistance percentage. However, in accordance with Federal regulations at 42 CFR 438.812(b)(2), during the periods that services are provided in accordance with MCO, BHO, pharmacy benefit manager, or dental benefit manager nonrisk contracts, that portion of the State's payments that are for reimbursement of the nonrisk contractors' administrative services can only be claimed by the State as an administration cost at the Federal matching rates available for the costs of administration of the Medicaid program. The administrative services portion of the amounts paid by the State to compensate any nonrisk contractors for their administration costs incurred in accordance with nonrisk contracts are costs of the demonstration waiver that are subject to the budget neutrality limitations explained at Attachment B.

    b. Actual cash disbursements made by the State from a supplemental pool, excluding the one-time DY #04 (i.e., State fiscal year (SFY) 2006) $50 million dollar special hospital pool payment covered under Attachment G or any other prior approved payment methodologies, to reimburse participating TennCare providers for their unreimbursed costs (including any medical education costs that are not classified as graduate medical education (GME) costs) for TennCare covered services rendered to the enrollees, as well as those eligible but not enrolled (EBNE). CMS will only approve FFP for supplemental pool payments made in accordance with pool distribution methodologies that have been given prior CMS approval.

        Actual cash disbursements made by the State during DY #04 (i.e., SFY 2006) from the one-time $50 million special hospital pool payment in accordance with the distribution methodology approved in Attachment G to the STCs.

        Payments to providers that are not reimbursed based on cost, such as physicians, will be exempt from cost reconciliations.

    c. Actual cash disbursements made by the State from a supplemental pool to pay for GME costs in accordance with the pool distribution methodology that has been given prior CMS approval. CMS will only approve FFP for supplemental pool payments made in accordance with pool distribution methodologies that have been given prior CMS approval.

    d. Actual expenditures CPE to have been incurred by those public hospitals for TennCare

enrollees and those EBNE, but only to the extent that the State is able to document that the public hospital had an actual un-reimbursed cost for providing those TennCare covered hospital inpatient and outpatient services which exceeded the amounts paid to that hospital from the following sources: the MCOs; the BHOs, the TennCare eligibles, TennCare supplemental pools, GME funds received from the GME universities that are for the reimbursement of costs incurred for the provision of the TennCare covered services, and other sources (except for local government indigent care funds).

e. Actual expenditures for providing services to a TennCare enrollee residing in an IMD for the first 30 days of an inpatient episode, subject to an aggregate annual limit of 60 days and the following limitations:

DY	Period	Allowable Portion of Expenditures
01	July 1, 2002 - June 30, 2003	100%
02	July 1, 2003 - June 30, 2004	100%
03	July 1, 2004 - June 30, 2005	100%
04	July 1, 2005 - June 30, 2006	50%
05	July 1, 2006 - June 30, 2007	0%

6. Report all administrative and service expenditures and revenue collections allowed under the waiver approved for this demonstration project in such a manner as agreed upon by the parties. Do not include expenditures related to research and evaluation activities. If the State requests, and if CMS approves Federal funding for such research and evaluation activities, then those expenditures may be funded under other Federal authority.

7. The State must allocate the TennCare premiums collected in accordance with the following scheduled percentage:

DY	Period	Allowable as State Share	Report as Collections
01	July 1, 2002 - June 30, 2003	80%	20%
02	July 1, 2003 - June 30, 2004	60%	40%
03	July 1, 2004 - June 30, 2005	40%	60%
04	July 1, 2005 - June 30, 2006	20%	80%
05	July 1, 2006 - June 30, 2007	0%	100%

Premiums that must be reported as collections should be reported on Line 9E of the Form CMS-64 Summary Sheet.

Attachment E

SUMMARY OF MEDICALLY NEEDY AND TENNCARE STANDARD ELIGIBILITY REDETERMINATION AND DISENROLLMENT PROCESS

This Attachment summarizes the processes Tennessee will use to: (i) redetermine eligibility and terminate the adult (non-pregnant) Medically Needy; and (ii) disenroll adults who are TennCare/Medicare dual eligible, uninsured, and Medically Eligible.

Termination of Adult Non-Pregnant Medically Needy

1. Ex Parte Review

A. The State will conduct a data match of the Social Security numbers of individuals classified as adult non-pregnant Medically Needy in its InterChange Information System (which contains information on TennCare enrollees) with Social Security Administration (SSA) data to determine whether the individual has lost supplemental security income (SSI) eligibility for reasons that would qualify them as Medicaid eligible.[1]

B. The State will conduct a data match of the Social Security numbers (SSNs) of individuals classified as adult non-pregnant Medically Needy in InterChange with individuals classified as participants in its Food Stamps or Families First (TANF) program in its ACCENT system (a database maintained by the Department of Human Services (DHS)). In all instances in which there is a match between an adult Medically Needy individual with an individual with an open Food Stamps or Families First record, the State will evaluate the individual's information to determine whether they qualify for any open TennCare Medicaid categories.

2. Request for Information

A. At least 30 days prior to the end of the individual's current eligibility period, the State will send notification (Request for Information) to those adult non-pregnant Medically Needy enrollees who have not been identified through the ex parte review process as eligible for open categories of TennCare Medicaid.

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1 Such reasons include (i) they lost SSI eligibility because of Social Security cost of living adjustment(s) ("COLA(s)") but would be SSI eligible if the COLA(s) was/were disregarded ("Passalong" eligibles); (ii) they lost SSI eligibility for some reason other than a Social Security COLA, but would be eligible for SSI if the COLA(s) received since their SSI termination was/were disregarded ("Pickle" eligibles); or (iii) they are entitled to Medicaid coverage pursuant to Daniels, et al. v. Tenn. Dept. of Health and Env't, et al., No. 79-3107 (Dist. Tenn.). Pursuant to an injunction issued in Daniels, Tennessee is required to maintain TennCare Medicaid eligibility for individuals who lost SSI at any time since November 13, 1987.

B. The Request for Information will:

i. Inform enrollees that their eligibility category for Medicaid is ending, and that they will only remain eligible for TennCare Medicaid if they qualify for open Medicaid categories.

ii. Provide enrollees with 30 days from the date of the Request for Information to provide the State with all of the necessary information for DHS to determine whether the individual is eligible for a Medicaid category that is not ending (i.e., completion of an attached form and verifications). The Request for Information will inform enrollees of the ways in which they may qualify for open Medicaid categories. The Request for Information will include a form to be completed with the information needed to determine eligibility for TennCare Medicaid as well as a list of the types of proof needed to verify certain information.

iii. Inform enrollees that if they do not submit information within 30 days from the Request for Information, DHS will be unable to find the enrollee eligible for Medicaid and the enrollee will receive an advance notice that will provide appeal rights.

iv. Inform enrollees that the State will have the discretion to extend the 30-day timeframe in which to submit information for good cause on a case-by-case basis, but such extensions will be limited to rare personal situations such as serious illness and DHS' decisions on granting good cause exceptions will not themselves be fair hearable.

C. Enrollees with disabilities will have the opportunity to seek additional assistance in responding to the Request for Information. The Request for Information will be translated in Spanish, and additional translation assistance in other languages will be made available for individuals with Limited English Proficiency. Upon request, the State will also make special accommodations for individuals with qualifying assessments in the previous 12 months as Seriously and/or Persistently Mentally Ill (SPMI). Such accommodations will be provided to this population in accordance with the timelines and processes addressed in the State's policies and procedures.

D. If enrollees submit the requisite information during the 30-day time period following the Request for Information, they will retain their eligibility for TennCare Medicaid (subject to applicable changes in the TennCare Medicaid benefit package—i.e., elimination of pharmacy coverage for adult non-institutionalized non-pregnant Medically Needy) until DHS determines that the individual does not qualify for open categories of TennCare Medicaid (and proper termination and appeal processes have been completed).

E. If enrollees provide some but not all of the necessary information to DHS to determine whether enrollees qualify for open categories of TennCare Medicaid during the 30-day period following the Request for Information, the State will send these enrollees a "Verification Request." Verification Requests will inform enrollees that they must submit the missing information to DHS within 10 days from the date of the Verification Request in order for DHS to determine whether enrollees qualify for open categories of TennCare Medicaid (subject to applicable changes in the TennCare Medicaid benefit package). If enrollees submit all of the remaining requested information during this 10-day time period, enrollees will retain TennCare Medicaid coverage until DHS determines that the individual does not qualify for open categories of TennCare Medicaid (and proper termination and appeal processes have been completed). If no additional information is submitted (or if some but not all of the additional information is submitted), enrollees will retain Medicaid coverage while DHS reviews the information the enrollee has previously provided and makes an eligibility determination.

F. If the State makes a determination that an enrollee is eligible for Medicaid, DHS will so notify the enrollee and the enrollee will be enrolled in the appropriate TennCare Medicaid category. The State will make the determination that enrollees are not eligible for open TennCare Medicaid categories in the following two scenarios: (i) if enrollees submit information either during the 30-day period following the Request for Information or during the 10-day period following the Verification Request and upon review, DHS determines that the enrollees do not qualify for open categories of TennCare Medicaid; or (ii) if enrollees do not submit the requisite information during the 30-day period following the Request for Information.

3. **Expiration Notice**

A. Upon making a determination that enrollees are no longer eligible for TennCare Medicaid, the State will provide a notice (Expiration Notice) to enrollees at least 20 days in advance of the end date of the enrollees' eligibility period.

B. Expiration Notices will:

i. Inform enrollees that they will be terminated from Medicaid as of a date specified in the notice because their current eligibility period has ended, their category of TennCare Medicaid is closed and they have not proven their eligibility for other open categories of TennCare Medicaid.

ii. Provide enrollees with 40 days (inclusive of mail time) from the date of the Expiration Notice to request a hearing for factual disputes related to the termination and inform enrollees how they may request a hearing.

iii. Inform enrollees that if they request a hearing prior to the date of termination specified in the Notice, Medicaid benefits for non-pregnant Medically Needy (subject to changes in the benefit package) will continue until the appeal has been resolved.

C. If enrollees submit information to qualify for Medicaid prior to their termination, enrollees will continue to be eligible for TennCare Medicaid for non-pregnant Medically Needy (subject to changes in the TennCare Medicaid benefit package) pending the determination as to whether the individual is eligible for other open TennCare Medicaid categories.

4. **Appeals Process**

A. Enrollees will have the right to request a hearing for 40 days (inclusive of mail time) from the date of the Expiration Notice.

B. The State will grant hearings only for those enrollees raising valid factual disputes related to the termination. Appeals that do not raise a valid factual dispute will be dismissed without a hearing. Valid factual disputes include:

i. Enrollees received the Expiration Notice in error (i.e., they are currently enrolled in other categories of TennCare Medicaid including Medically Needy pregnant women or enrollees under 21 years of age);

ii. The State failed to timely process information submitted by the enrollee during the requisite time period following the Request for Information or Verification Request;

iii. The State granted a "good cause" extension of time to reply to the Request for Information but failed to extend the time;

iv. Enrollees requested assistance because of a health, mental health, learning problem, or disability but the State failed to provide this assistance; or

v. The State sent the Expiration Notice to the wrong address as defined under State law.

C. The DHS staff will review the request for a hearing to determine if it is based on a valid factual dispute. An initial staff determination that the request for a hearing is not based on a valid factual dispute will be reviewed by a DHS attorney and if confirmed, the attorney will send notification to the appellant informing him/her of the following: (i) that there is no indication of a valid factual dispute; (ii) that the appellant has 10 days in which to provide additional clarification of any issue of factual dispute on which his/her appeal is based; and (iii) unless such clarification is timely received, a fair hearing will not be granted.

i. If the appellant does not respond within 10 days, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be terminated from the program.

ii. If the appellant submits additional information during this 10-day period and such information does not alter the attorney's initial determination that there is no valid factual dispute, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be terminated from the program.

iii. If the appellant provides additional information during the 10-day period that establishes a valid factual dispute, a second letter will be sent so advising the appellant and the appeal will proceed to a hearing.

D. When an enrollee requests a hearing prior to the date of termination identified in the Expiration Notice, TennCare Medicaid benefits will continue either until the State determines that the enrollee has not raised a valid factual dispute as described above, or the appeal is resolved.

E. If the enrollee does not request a hearing prior to the date of termination identified in the Expiration Notice, the enrollee will be disenrolled from TennCare Medicaid.

F. If the enrollee is granted a hearing and the hearing decision sustains the State's action, the State reserves its right to recover from the enrollee the cost of services provided during the hearing process.

II. Disenrollment of Adult Medicare/TennCare Dual Eligible, Uninsured, Medically Eligible

1. Ex Parte Review

A. The State will conduct a data match of the SSNs of individuals classified as adult Medicare/TennCare Dual Eligible, Uninsured or Medically Eligible enrollees in InterChange (which contains information on TennCare enrollees) with SSA data to determine whether the individual has lost SSI eligibility for reasons that would qualify them as Medicaid eligible.[2]

B. The State will conduct a data match of the SSNs of individuals classified as adult Medicare/TennCare Dual Eligible, Uninsured or Medically Eligible enrollees in Interchange with individuals classified as participants in the State's TANF program in DHS' ACCENT system. In all instances when there is a match

2 See footnote 1.

between an adult member of these demonstration populations with an individual with an open TANF record, the State will evaluate the individual's information to determine whether they qualify for any open TennCare Medicaid categories.

2. Request for Information

A. At least 30 days prior to disenrollment, the State will send a Request for Information to all adult Medicare/TennCare Dual Eligible, Uninsured, and Medically Eligible enrollees not identified through the ex parte review process as eligible for TennCare Medicaid.

B. The Request for Information will:

i. Inform enrollees that their eligibility category for TennCare Standard is ending and that they will only maintain coverage if they qualify for open Medicaid categories.

ii. Provide enrollees with 30 days from the date of the Request for Information to provide the State with all of the necessary information for DHS to determine whether the individual is eligible for Medicaid (i.e., completion of an attached form and verifications). The Request for Information will inform enrollees of the ways in which they may qualify for TennCare Medicaid. The Request for Information will include a form to be completed with the information needed to determine eligibility for TennCare Medicaid as well as a list of the types of proof needed to verify certain information.

iii. Inform enrollees that if they do not submit information within 30 days from the Request for Information, DHS will be unable to find the enrollee eligible for TennCare Medicaid and the enrollee will receive a Disenrollment Notice prior to disenrollment from TennCare Standard.

iv. Inform enrollees that the State will have the discretion to extend the 30-day timeframe in which to submit information for good cause on a case-by-case basis, but such extensions will be limited to rare personal situations such as serious illness and DHS' decisions on granting good cause exceptions will not themselves be fair hearable.

C. Enrollees with disabilities will have the opportunity to seek additional assistance in responding to the Request for Information. The Request for Information will be translated in Spanish, and additional translation assistance in other languages will be made available for individuals with limited English proficiency. Upon request, the State will also make special accommodations for individuals with qualifying assessments in the previous 12 months as SPMI. Such

accommodations will be provided to this population in accordance with the timelines and processes addressed in the State's policies and procedures.

D. If enrollees submit the requisite information during the 30-day time period following the Request for Information, they will retain their eligibility for TennCare Standard until DHS determines that the individual does not qualify for open categories of Medicaid (and proper disenrollment and appeal processes have been completed).

E. If enrollees provide some but not all of the necessary information to DHS to determine whether enrollees qualify for open categories of TennCare Medicaid during the 30-day period following the Request for Information, the State will send these enrollees a Verification Request. Verification Requests will inform enrollees that they must submit the missing information to DHS within 10 days from the date of the Verification Request in order for DHS to determine whether enrollees qualify for open categories of TennCare Medicaid. If enrollees submit all of the remaining requested information during this 10-day time period, enrollees will retain coverage until DHS determines that the individual does not qualify for open categories of TennCare Medicaid (and proper disenrollment and appeal processes have been completed). If no additional information is submitted (or if some but not all of the additional information is submitted), the enrollee will retain coverage while DHS reviews the information the enrollee has previously provided and makes an eligibility determination.

F. If the State makes a determination that an enrollee is eligible for Medicaid, DHS will so notify the enrollee and the enrollee will be enrolled in appropriate TennCare Medicaid category. The State will make the determination that enrollees are no longer eligible for TennCare in the following two scenarios: (i) if enrollees submit information either during the 30-day period following the Request for Information or during the 10-day period following the Verification Request and upon review, DHS determines that the enrollees do not qualify for open categories of TennCare Medicaid; or (ii) if enrollees do not submit the requisite information during the 30-day period following the Request for Information.

3. **Termination Notice**

A. Upon determination or confirming that enrollees are not eligible for TennCare Medicaid, the State will provide a Termination Notice to enrollees 20 days in advance of the date upon which the coverage will be terminated.

B. Termination Notices will:

i. Inform enrollees that they will be disenrolled from TennCare as of the date specified in the Notice (20 days after the date of the Notice) because their category of TennCare Standard is ending and they have not proven their eligibility for open TennCare Medicaid categories.

ii. Provide enrollees with 40 days (inclusive of mail time) from the date of the notice to appeal factual disputes related to the action of disenrollment and inform enrollees how they may request a hearing.

iii. Inform enrollees that if prior to the date of disenrollment specified in the Termination Notice, an enrollee appeals the action of disenrollment, he or she will not lose eligibility for TennCare until the State determines that the enrollee has not raised a valid factual dispute or the appeal is resolved.

iv. Inform enrollees that they may submit new information to demonstrate Medicaid eligibility at any time before or after disenrollment. Such information will be treated as a new application for Medicaid. The enrollee will not continue benefits pending the State's review and processing of this information.

4. **Appeals Process**

A. Enrollees will have the right to request a hearing for 40 days (inclusive of mail time) from the date of the Termination Notice.

B. The State will grant hearings only for those enrollees raising valid factual disputes related to the action of disenrollment. Appeals that do not raise a valid factual dispute will not proceed to a hearing. Valid factual disputes include:

i. Enrollee received the Termination Notice in error (e.g., he or she is currently enrolled in Medicaid or in a TennCare Standard category that is not ending);

ii. The State failed to timely process information submitted by the enrollee during the requisite time period following the Request for Information or Verification Request;

iii. The State granted a "good cause" extension of time to reply to the Termination Notice but failed to extend the time;

iv. Enrollee requested assistance because of a health, mental health, learning problem, or disability, but the State failed to provide this assistance; or

v. The State sent the Termination Notice to the wrong address as defined under State law.

C. The DHS staff will review the request for a hearing to determine if it is based on a valid factual dispute. An initial staff determination that the appeal is not based on a valid factual dispute will be reviewed by a DHS attorney and if confirmed, the attorney will send notification to the appellant informing him/her of the following: (i) that there is no indication of a valid factual dispute; (ii) that the appellant has 10 days in which to provide additional clarification of any issue of factual dispute on which his/her appeal is based; and (iii) unless such clarification is timely received, a fair hearing will not be granted.

i. If the appellant does not respond within 10 days, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be disenrolled.

ii. If the appellant submits additional information during this 10-day period and such information does not alter the attorney's initial determination that there is no valid factual dispute, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be disenrolled.

iii. If the appellant provides additional information during the 10-day period that establishes a valid factual dispute, a second letter will be sent so advising the appellant and the appeal will proceed to a hearing.

D. When an enrollee requests a hearing prior to the date of disenrollment as identified in the Termination Notice, TennCare Standard benefits will continue either until the State determines that the enrollee has not raised a valid factual dispute, or the appeal is resolved.

E. If the enrollee does not appeal prior to the date of disenrollment as identified in the Termination Notice, the enrollee will be disenrolled from TennCare Standard.

F. If the enrollee is granted a hearing and the hearing decision sustains the State's action, the State reserves its right to recover from the enrollee the cost of services provided during the hearing process.

Attachment F

SUMMARY OF NOTICE AND APPEALS PROCESS FOR CHANGES IN COVERAGE OF TENNCARE BENEFITS

This Attachment summarizes the processes Tennessee will use upon and after the implementation of changes in coverage of TennCare benefits.

I. Implementation of Changes in Coverage Policies

1. Initial Notice

A. At least 30 days prior to the effective date of changes in coverage of TennCare benefits (e.g., implementation of pharmacy benefit limits and elimination of covered services), the State shall provide a notice (Benefit Notice) to enrollees who are impacted by such changes in coverage of TennCare benefits.

B. Benefit Notices will:

i. Inform enrollees of how changes in coverage of TennCare benefits will apply to enrollees.

ii. Provide enrollees with 40 days (inclusive of mail time) from the date of the Benefit Notice to request a hearing for valid factual disputes related to the changes in coverage and inform enrollees how they may request a hearing.

iii. Inform enrollees that if they request a hearing for a valid factual dispute prior to the effective date of the change in coverage of TennCare benefits, benefits will be continued at the level for the eligibility category alleged by the enrollee to be currently applicable until the appeal has been resolved. If the alleged eligibility category is not immediately apparent, the enrollee's benefits will be continued at the level for Non-Institutionalized Medicaid Adults (Default Level). The State will apply the Default Level of benefits until the appeal has been resolved, unless the State subsequently determines that the enrollee is alleging that a different eligibility category is currently applicable at which time the enrollee's level of benefits will be adjusted as necessary. (The resolution of an appeal, for purposes of this Attachment, is defined as when the appeal is dismissed or resolved prior to a hearing or when a decision is rendered at or after the hearing.)

2. Appeals Process

A. An enrollee will have the opportunity to request a State fair hearing for 40 days (inclusive of mail time) from the date of the Benefit Notice.

B. The State will grant State fair hearings only for those enrollees raising valid factual disputes related to the changes in coverage. Appeals that do not raise a valid factual dispute will be dismissed without a hearing. A valid factual dispute is a factual dispute that, if resolved in the enrollee's favor, would entitle the enrollee to a different level of TennCare benefits than that identified in the Benefit Notice. Valid factual disputes include when an enrollee claims to have received the Benefit Notice in error (e.g., he or she is already in a TennCare category that is not subject to the particular changes in coverage).

C. When an enrollee requests a hearing prior to the effective date of changes in coverage as identified in the Benefit Notice, the enrollee shall continue to receive benefits at the level for the eligibility category alleged by the enrollee to be currently applicable until the appeal has been resolved. If the alleged eligibility category is not immediately apparent, the enrollee's benefits will be continued at the Default Level. The State will apply the Default Level until the appeal has been resolved, unless the State subsequently determines that the enrollee is alleging that a different eligibility category is currently applicable at which time the enrollee's level of benefits will be adjusted as necessary.

D. If the enrollee appeals, the changes in coverage in dispute shall become effective upon resolution of the appeal.

E. If the enrollee does not appeal prior to the effective date of changes in coverage as identified in the Benefit Notice, such changes in benefits will become effective, as applied to the enrollee, upon this date.

F. If the enrollee appeals and: (i) the appeal is dismissed because the enrollee has not asserted a valid factual dispute; or (ii) the enrollee is granted a hearing and the hearing decision sustains the State's action, the State reserves its right to recover from the enrollee the cost of services provided as a result of the appeal.

II. Post-Implementation Appeals from Denials of Prior Authorization for Pharmacy Products

1. Prior Authorization Requirements

A. Any prescription of a branded drug may be subjected to a prior authorization requirement by the State; and prior authorization will be required as a condition of coverage for branded prescription drugs that are not included on the State's Preferred Drug List.

B. Physicians (or other providers with prescribing authority) participating in TennCare will be responsible for requesting prior authorization, according to procedures to be established by the State.

2. Notice of Prior Authorization Denial

A. Requests for prior authorization of covered outpatient drugs shall be transmitted to and acted upon by appropriate staff of the Pharmacy Benefit Manager (PBM) Clinical Call Center.

B. Written notice of denial of a request for prior authorization shall be mailed by the PBM on behalf of the State to the enrollee and transmitted by facsimile to the prescribing physician. Such Notice will inform the enrollee that the request for prior authorization of the prescribed drug has been denied and that TennCare does not cover the drug absent prior authorization, briefly state the reason or reasons for denial of the request, explain the procedures that are available to the enrollee to appeal from that decision, and inform the enrollee that TennCare will not cover the cost of the prescribed medication during the pendency of any appeal. The State's failure to act on a request for prior authorization within a 24-hour period after receiving a submission that complies with the State's requirements for a completed prior authorization request may be deemed a denial from which the enrollee can appeal.

3. Procedures for Filing and Pursuing an Appeal

A. Appeals of denials of requests for prior authorization may be initiated within 20 days of the Notice of denial of prior authorization, at the option of the enrollee, by the enrollee (or an individual appointed or otherwise authorized under State law to act as the enrollee's representative) submitting to the TennCare Solutions Unit via hand delivery, mail, or facsimile, a written statement of intent to appeal on a form prescribed by the State. Such form will be available on the PBM Web site, and the TennCare Web site, at local Health Departments, from TennCare participating pharmacies, through member services of the enrollee's managed care organization (MCO), or from the TennCare Solutions Unit. Undue delay by the State in deciding a prior authorization request (i.e., delay in excess of the 24-hour period permitted for such decisions) will be considered a denial of prior authorization for purposes of appeal.

B. The State will dismiss any appeal that does not raise a valid factual dispute without a hearing, and will retain the authority to determine whether an appeal raises a valid factual dispute relating to denial of a prior authorization request or the State's failure to act on a request for prior authorization within a 24-hour period after such request. A valid factual dispute is a factual dispute that, if resolved in favor of the enrollee, would entitle the enrollee to coverage for the prescribed drug. A dispute concerning whether a particular drug or dosage is medically necessary for the enrollee, will be considered a valid factual dispute.

C. An initial determination on appeals involving issues of medical necessity will be made by appropriately qualified medical professionals on the staff of the TennCare Solutions Unit as promptly as possible after the enrollee's submission of the appeal. After submission of the appeal, the TennCare Solutions Unit may seek additional information or documentation in support of the appeal, before any initial determination is made.

D. Upon initially deciding an appeal, the State shall send a letter communicating its decision to the enrollee and stating the reasons for that decision, and shall also communicate any decision granting prior authorization to the enrollee and/or the prescribing physician by the fastest means practicable. A letter initially denying an appeal shall also inform the enrollee of his or her opportunity to request a State fair hearing, and the procedures that must be followed to pursue such further appeal.

4. Benefits During the Pendency of an Appeal

A. During the pendency of any appeal from denial of a pharmacy service due to the lack of required prior authorization, the enrollee will continue to be eligible for pharmacy benefits within applicable pharmacy service limits, but will not have any right to receive on a covered basis the drug that is the subject of the appeal.

B. If the enrollee chooses to purchase the unauthorized, prescribed drug at his or her own expense, the enrollee will be entitled to reimbursement of the costs of the drug upon prevailing in his or her appeal, but only to the extent that applicable, monthly pharmacy benefit limits would not thereby be exceeded.

III. Post Implementation Appeals of Application of Benefit Limits

1. Initial Notice

A. Pharmacists will be required to verify TennCare coverage for all prescriptions presented by enrollees through an electronic database maintained by the PBM. If, through the database, the PBM denies coverage of a prescription because the enrollee has reached or exceeded the monthly pharmacy benefit limit ("the pharmacy limit"), the PBM on behalf of the State will mail a written notice of the denial to the enrollee (Service Notice). Service Notice shall be provided only upon the first denial of coverage of a pharmacy service sought by the enrollee that exceeds the monthly five prescription limit, and/or upon the first denial in that month of a pharmacy service sought by the enrollee that exceeds the two prescriptions limit on branded drugs. (For purposes of this Attachment F, "the pharmacy limit" is defined as a five prescription limit per month, of which no more than two prescriptions or refills could be for branded drugs and at least three

out of any five prescriptions or refills in the same month must be for generic drugs.)

B. If a pharmacist fills a prescription in excess of the pharmacy limit and submits a claim for such service, the PBM will deny payment for the claim. Upon denial of payment for such claim, the PBM on behalf of the State will mail a written notice (Notice of Limit) to enrollees.

C. If a provider denies a non-pharmacy service or charges the enrollee for the service because the enrollee has reached or exceeded a benefit limit, the provider need not give specific notice of appeal rights to the enrollee but must direct the enrollee to the responsible arm of the managed care contractor (MCC).

D. If a provider renders a non-pharmacy service in excess of a non-pharmacy benefit limit and the provider or the enrollee submits a claim for such service, the MCC will deny payment for the claim. Upon denial of payment for such claims, the MCC, on behalf of the State, will mail a Notice of Limit to enrollees. A Notice of Limit shall be provided only upon the first denial of coverage of a non-pharmacy service sought by the enrollee that exceeds the applicable limit for the kind and number of services during a given time period specified in the State's program.

E. The Notice of Limit and Service Notice will:

i. Inform an enrollee that he or she has reached or exceeded the applicable benefit limit.

ii. Provide enrollees with at least 20 days from the Notice of Limit or Service Notice to request a hearing for valid factual disputes related to the benefit limit and inform enrollees how they may request a hearing.

iii. Inform enrollees that if they request a hearing, they will not receive continuation of benefits (i.e., services in excess of the applicable limit) during the pendency of their appeal.

iv. Remind enrollees of any exceptions to the limits and inform them how to obtain more information about such exceptions.

2. <u>Appeals Process</u>

A. Enrollees will have the opportunity to request a State fair hearing for at least 20 days from the date of the Notice of Limit or Service Notice.

B. The enrollee will be required to submit a designated form in order to request a State fair hearing. The form, which must be signed by the enrollee (or an individual appointed or otherwise authorized to act as the enrollee’s representative under State law), would include the basis for the appeal and the enrollee must

attest, under penalty of perjury, that his contention is true to the best of his knowledge and is made in good faith. Enrollees may obtain this form on the PBM Web site, the TennCare Web site, at local Health Departments, from TennCare participating pharmacies, through member services of the enrollee's MCO, or from the TennCare Solutions Unit. Absent a grant by the State at its discretion of an exemption from a signature requirement due to special circumstances, an appeal will not be deemed to be filed unless this form has been signed by the enrollee or by an individual authorized under State law to act as the enrollee's representative.

C. The State will grant a State fair hearing only for those enrollees raising valid factual disputes related to the benefit limit. Appeals that do not raise a valid factual dispute will be dismissed without a hearing. A valid factual dispute is a factual dispute that, if resolved in favor of the enrollee, would entitle the enrollee to coverage for the service that was denied because the enrollee had reached or exceeded the applicable benefit limit. Valid factual disputes include:

i. An administrative error was allegedly made and the enrollee has not yet reached the relevant benefit limit.

ii. The enrollee alleges that his or her circumstances have changed and he or she has been re-classified in a TennCare eligibility category that is not subject to the benefit limit the State has applied. The State, however, shall not grant a hearing to individuals who allege solely that they are not subject to the benefit limit without further alleging a change of circumstances that has been reported to TennCare and has resulted in a change in their eligibility category. These enrollees will be granted a hearing because they did not have the opportunity to appeal the application of the benefit limit to them in connection with the Benefit Notice.

iii. The enrollee alleges an administrative error in the processing of a request for a special exemption to the benefit limit (i.e., the enrollee's physician submitted the required attestation necessary to obtain a special exemption from the benefit limit and the prescribed drug is on the special exemption list but coverage for the drug was nonetheless denied).

D. The enrollee shall not receive continuation of benefits when appealing a denial of services based on the application of a benefit limit. This policy shall apply even for items or services that have been previously authorized as medically necessary to the extent that the denial of services is based on the application of a benefit limit.

E. If the enrollee chooses to receive the benefits in dispute pending an appeal at his or her own expense, the enrollee will be entitled to reimbursement of the costs of

the benefits in dispute upon prevailing in his or her appeal with respect to those benefits.

F. If the enrollee does not request a hearing, the benefit limit deemed applicable by the State will continue to apply to the enrollee.

G. Providers will be permitted to bill enrollees for services that were provided in excess of the benefit limits.

IV. Post Implementation Appeals of Elimination of Coverage for Certain Services

1. Neither the State nor the MCC will provide notification in addition to the Benefit Notice described above with respect to services that are eliminated from TennCare coverage as those services are no longer covered by TennCare.

2. Upon denial of non-covered services, TennCare enrollees will have the opportunity to request a State fair hearing. The enrollee will be required to submit a designated form in order to request a hearing. Such form would include a statement, which must be signed by the enrollee, or an individual appointed or otherwise authorized to act as the enrollee's representative under State law that sets out or describes the factual contention on which the appeal is based, and attests, under penalty of perjury, that the contention is true to the best of the signatory's knowledge and is made in good faith. Enrollees or their representatives may obtain this form on the PBM Web site, the TennCare Web site, at local Health Departments, from TennCare participating pharmacies, through member services of the enrollee's MCO, or from the TennCare Solutions Unit. Absent a grant by the State at its discretion of an exemption from the signature requirement due to special circumstances, an appeal will not be deemed to be filed unless this form has been signed by the enrollee or his/her authorized representative.

3. The State will grant a State fair hearing only for those enrollees who raise valid factual disputes related to the elimination of coverage. A valid factual dispute is a factual dispute that, if resolved in the enrollee's favor, would entitle the enrollee to coverage of the disputed service. In the context of excluded services, valid factual disputes are limited to when an enrollee claims that he or she is already in a TennCare category that is entitled to coverage of the particular service at issue. Appeals that do not raise a valid factual dispute will be dismissed without a hearing.

4. If the request for a hearing is granted, the enrollee will not receive continuation of the benefits in dispute pending the appeal.

5. If the enrollee chooses to receive the benefits in dispute pending an appeal at his or her own expense, the enrollee may be entitled to reimbursement of the costs of the benefits in dispute upon prevailing in his or her appeal.

Attachment G

SFY 2006 Methodology for $50 Million Special Hospital Pool Payments

Eligible Hospitals

Hospitals eligible to receive an SFY 2006 Special Hospital Pool payment include all hospitals licensed to operate in the State of Tennessee excluding: the State mental health institutes; and the critical access hospitals. The critical access hospitals receive cost-based reimbursement from the TennCare program and therefore do not have any unreimbursed TennCare costs.

Allocation of the Pool to Segments of Hospitals

The $50 million Pool, which represents combined Federal and State funds, should be segmented into 4 distinct parts as follows:

- **Essential Service Safety Net – $25 Million**

  These hospitals are defined as any hospital that is both a Level 1 Trauma Center and a Regional Perinatal Center or any metropolitan public hospital that is contractually staffed and operated by a safety net hospital for the purpose of providing clinical education and access to care for the medically underserved.

- **Children's Safety Net – $2.5 Million**

  These hospitals are defined as any hospital licensed by the Tennessee Department of Health whose primary function is to serve children under the age of 21 years in Tennessee.

- **Free Standing Psychiatric Hospitals - $1 Million**

  These hospitals are defined as hospitals licensed by the Tennessee Department of Mental Health and Developmental Disabilities for the provision of psychiatric hospital services in Tennessee, excluding the State Mental Health Institutes.

- **Other Essential Acute Care – $21.5 Million**

  These hospitals include all other TennCare participating hospitals licensed by the Tennessee Department of Health to provide services in Tennessee excluding the critical access hospitals.

Data

Calculation of the SFY 2006 payments will be based on the 2003 Joint Annual Report of Hospitals.

Minimum qualifications

In order to receive a payment, the non free standing psychiatric hospitals must be a contracted provider with TennCare Select and, where available, at least one other Managed

Care Organization in the TennCare program. In order to receive a payment, the free standing psychiatric hospitals must be a contracted provider with at least one of the Behavioral Health Organizations in the TennCare program. All hospitals (unless they are capitated and accept the capitation as full reimbursement) must have unreimbursed TennCare Cost.

Minimum qualification for all acute care hospitals:
Each qualifying hospital must have 13.5% or more of its total TennCare adjusted days.

- OR -

A hospital may qualify if TennCare adjusted days are 9.5% or more of the total adjusted days and the number of adjusted days for the hospital is higher than the average number of TennCare Adjusted Days. (7,738 days for all of the hospitals in the 'Other Essential Acute Care' group that reported any TennCare utilization on the 2003 Joint Annual Report – excluding the Critical Access Hospitals).

Minimum qualifications for Freestanding Psychiatric hospitals:
At least 30% of total patient days are attributable by TennCare.

Allocation will be based on an assignment of points for:

- TennCare adjusted days expressed as a percent of total adjusted patient days,
- Charity, medically indigent care, and bad debt expressed as a percent of total expenses,

Calculation of Points
(1) TennCare volume is defined TennCare adjusted days as the percent of hospital's total adjusted days. Points are assigned based on that percent as follows:

- 1 point – greater than or equal to 9.5% but less than 13.5% and the actual number of TennCare adjusted days must be greater than the average for all acute care hospitals, excluding the critical access, pediatric and safety net providers;
- 1 point – greater than or equal to 13.5% and less than or equal to 24.5%;
- 2 points – greater than 24.5% and less than or equal to 34.5%;
- 3 points – greater that 34.5% and less than or equal to 49.5%;
- 4 points – greater than 49.5%.

(2) Bad Debt, Charity and Medically Indigent – BDCHMI costs as a percent of total expenses

- 0 points – less than 4.5%
- 1 point - greater than or equal to 4.5% and less than 9.5%
- 2 points - greater than or equal to 9.5% and less than 14.5%
- 3 points - greater than or equal to 14.5%

Calculation of Amounts of Payments for Hospitals
These points will then be used to adjust the General Hospital Rate (GHR) based on pre-TennCare hospital reimbursement rates. The GHR rate included all inpatient costs

(operating, capital, direct education) but excluded add ons (indirect education, MDSA, return on equity).

The GHR for Safety Net Hospitals is $908.52. The GHR for Other Essential Access Hospitals is $674.11. The points for each qualifying hospital will be summed and then used to determine the percent of the GHR that is used to calculate the initial payment amount for each hospital.

- 7 points – 100% of GHR
- 6 points – 80% of GHR
- 5 points – 70% of GHR
- 4 points – 60% of GHR
- 3 points – 50% of GHR
- 2 points – 40% of GHR
- 1 point - 30% of GHR

For each of the 4 pools, the appropriately weighted GHR for each qualifying hospital is multiplied by the number of TennCare adjusted days provided by the hospital. These adjusted amounts are summed for all of the hospitals that still qualify for the pool. Each hospital's calculated amount will then be adjusted to the total in the pool. This is done by multiplying the calculated amount for a hospital by the ratio of the total of the calculated amounts for all qualifying hospitals to the total amount of the pool allocated for that group. So, if the sum of the calculated amounts for the children's safety net group is $9 million and the total pool for these children's hospitals is $2.5 million, each hospital's calculated amount will be multiplied by the percentage derived from $2.5 million divided by $9 million. Because the final pool payments calculated in this manor must be limited to each hospital's cost of uncompensated care, any surplus payment amount above the cost of uncompensated care must be reallocated to any remaining qualifying hospitals that have not been fully compensated for their costs. The resulting values will be the amounts to be provided to the hospitals as an SFY 2006 Special Hospital Pool payment.

Payments

Hospitals will be paid on a one time basis following CMS approval. In order to receive a payment, all non-free standing psychiatric hospitals must be a contracted provider with TennCare Select and, where available, at least one other Managed Care Organization. In order for the free standing psychiatric hospitals to receive a payment, the free standing psychiatric hospitals must be a contracted provider with at least one of the Behavioral Health Organizations.

Attachment H

Enrollment in TennCare Standard Spend Down

Upon approval of the TennCare Standard Spend Down (SSD) demonstration amendment, the State will open SSD enrollment to two groups of individuals. One group (Category 1) consists of people who are not currently eligible for Medicaid and who meet the criteria for the new SSD program. The second group (Category 2) includes people who are currently eligible for Medicaid in the non-pregnant adult Medically Needy category, have completed their 12 months of Medicaid eligibility, have been found to be ineligible for any other Medicaid category, and meet the criteria for the new SSD program. Financial eligibility criteria for SSD will be based on criteria that apply to Medically Needy pregnant women and children eligible under the State Plan.

The State will establish separate processes for SSD enrollment for new applicants (Category 1) as compared to currently enrolled non-pregnant Medically Needy adults (Category 2). For Category 2 individuals, the State will determine their SSD eligibility on a rolling basis in conjunction with their disenrollment from Medicaid, and shall reserve sufficient slots within the enrollment target to ensure that all such persons who are eligible may be enrolled. Category 1 applicants will be enrolled only through a single toll-free telephone point of entry (the Call-In Line) initiated in periods of open enrollment. In each open enrollment period, the State will determine a specified number of calls that it will accept through the Call-In Line based on the number of Category 1 applications that, together with projected pending applications from Category 2, the State estimates it can process within Federal timeliness standards. The number of calls to be accepted in open enrollment periods will also be based on the number of remaining slots available under the enrollment target and the number of slots necessary to reserve for non-pregnant Medically Needy adults. The State will not accept or track calls received outside of open enrollment periods.

Once the State has reached its targeted enrollment of 100,000 persons, new open enrollment periods will be scheduled when enrollment in the SSD program drops to 90 percent of target enrollment. Any subsequent open enrollment periods will remain open until a pre-determined number of calls to the Call-In Line have been received. The number of calls to be received will be established based on the State's determination of the minimum number of applications necessary to fill open slots in the program and the number of applications the State estimates it can process in a timely manner in accordance with Federal standards. The State's decision to open or close enrollment is a policy decision that is within the State's discretion and the State is not required to provide fair hearings for challenges to these decisions.

Callers to the Call-In Line will be asked for basic demographic information and will be assigned a unique identifier. After conducting a match to verify that callers are not already enrolled in TennCare Medicaid, the State will send each non-enrolled caller a written application form, accompanied by a letter advising the individual of the requirement to complete, sign, and return the application within 30 days. (Those callers who are already enrolled in TennCare Medicaid will be sent letters advising them that they currently have benefits and need not apply.)

Completed signed applications received by the State by the 30-day deadline established by the State will be evaluated for Medicaid eligibility and SSD eligibility. Applications received after the deadline will not be reviewed for SSD eligibility but will still be processed for Medicaid eligibility. There will be no "good cause" exception to the written application deadline set by the State. If the individual does not mail back an application by the deadline, the State will send the individual a letter advising he or she that since no application was received, the State will not make an eligibility determination for him or her, but the individual is free to apply for SSD during any open enrollment period and to apply for Medicaid at any time. No hearings will be granted to individuals concerning this process who have not timely submitted signed applications unless the individual alleges a valid factual dispute that he or she did submit a signed, written application within the deadline. Since all SSD applications received during an open enrollment period will be processed and either approved or denied, there is no requirement for the State to maintain a "waiting list" of potential SSD applicants. No applications submitted in one open enrollment period will be carried forward to future open enrollment periods. The State will determine SSD eligibility within the timeframes specified by Federal regulations at 42 CFR 435.911; such timeframes will begin on the date a signed written application is received by the State.

The effective date of SSD eligibility for individuals whose enrollment is originally initiated through the Call-In Line and who submit a timely signed application will be the later of: 1) the date that their call was received by the Call-In Line; or 2) the date spend down is met (which must be no later than the end of the one-month budget period -- in this case, the end of the month of the original call to the Call-In Line). The effective date provisions contained in Attachment H only apply to SSD eligibility and do not apply to other categories of TennCare eligibility. All enrollees in the SSD demonstration category will have an eligibility period of 12 months from the effective date of the determination. At the end of the 12-month period the enrollee will need to have his eligibility status redetermined in order to establish SSD or Medicaid eligibility. The duration of the eligibility period for SSD eligibility is the same as that used for TennCare Medicaid.